STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676180	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elgin Nursing and Rehabilitation Center	1373 North Avenue C Elgin, TX 78621

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 6 residents (Resident #1) reviewed for care plans.The facility failed to develop and implement Resident #1's care plan to reflect the interventions placed for monitoring after being hit by another resident after a resident-to-resident altercation that occurred on 03/14/2026.This failure could place residents at risk of not receiving required interventions to meet their current needs.Findings included:Record review of Resident #1's admission record, dated 04/16/2026, reflected a [AGE] year-old male, admitted to the facility on [DATE] and most recently readmitted on [DATE], with diagnoses that included unspecified dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), generalized anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about every day issues, affecting daily functioning and quality of life), impulse disorder (a group of behavioral conditions that involve the inability to control impulses and behaviors) and cerebral infarction (a disruption in blood flow to the brain leading to brain cell death sometimes causing permanent disability).Record review of Resident #1's comprehensive MDS, dated [DATE], reflected Resident #1 had a BIMS score of 11, which indicated moderate cognitive impairment. Section E - Behavior reflected Resident #1 had no behaviors.Record review of Resident #1's care plan, dated 01/29/2019 and last revised 03/24/2026, reflected problem, The resident has a behavior problem AEB tearing diaper into pieces chewing on brief. Placing fingers in rectum and placing them in mouth and smelling hands and attempts to slid out of wheel chair and often laughing when he falls or is on the floor. Resident with noted sexual behaviors, fondles, touches himself and masturbates in public areas. Makes sexual comments to female staff. Exposes penis in public areas. History of entering others rooms uninvited. History of call a female resident a whore. History of inappropriate touching of another female resident. 5/22/22-Resident intentionally slide down his w/c, prefers to stand at times from w/c with interventions that included 3/14/2026: Continue to monitor for areas of concern related to contact with peer.Record review of facility incident report, 03/14/2026, reflected CNA [A] notified writer that [Resident #1] was hit in the face x2 by resident. States she saw [Resident #1] was sitting up in his wheelchair in hallway next to other resident, looking at him, before that resident proceeded to ball his fist up and hit [Resident #1] in the face. [Resident #1] was taken to dining room by CNA. Writer assessed [Resident #1], found no injuries to face or elsewhere. Questioned [Resident #1] if other resident hit him in the face, [Resident #1] states yes. Denies pain. Denies any feelings of fear or feeling unsafe. VS obtained: 114/46, 53, 97%RA, R-18, 97.4F, 1/10 pain. Reassured [Resident #1] that other resident would be kept separate and that [Resident #1] was safe. [Resident #1] smiles and states, okay, No further concerns or request. Remains sitting up in dining room watching TV, w/c (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	brakes locked. Plan of care ongoing. The incident report had no other mentions of the plan of care.During an interview on 04/16/2026 at 06:02 PM, the ADON stated she and the DON were responsible for updating care plans. She stated care plans were reviewed during the morning meetings to ensure accuracy. The ADON stated care plans were used by the floor staff to learn how to care for the residents. She stated the care plan for Resident #1 was updated after the resident-to-resident altercation in which Resident #1 was allegedly assaulted by another resident under the problem area The resident has a behavior problem AEB tearing diaper into pieces chewing on brief. Placing fingers in rectum and placing them in mouth and smelling hands and attempts to slid out of wheel chair and often laughing when he falls or is on the floor. Resident with noted sexual behaviors, fondles, touches himself and masturbates in public areas. Makes sexual comments to female staff. Exposes penis in public areas. History of entering others rooms uninvited. History of call a female resident a whore. History of inappropriate touching of another female resident. 5/22/22-Resident intentionally slide down his w/c, prefers to stand at times from w/c. The ADON stated the problem did not relate to the incident that had occurred. She stated by not updating the care plan with a problem that related to the incident the resident could have had psychosocial distress. The ADON stated there had not been any changes in Resident #1's psychosocial status since the incident occurred on 03/14/2026.During an interview on 04/17/2026 at 10:20 AM, the DON stated she started at the facility on 03/13/2026. She reviewed the care plan for the incident and stated the care plan revision for Resident #1 for the resident-to-resident altercation should have a problem related to the incident with relevant interventions. She stated the intervention for the resident-to-resident altercation for Resident #1 should have been listed under a problem related to monitoring for psychosocial harm. She stated care plan are used by the floor staff to obtain knowledge in caring for the residents and are updated because new things come up.During an interview on 04/17/2026 at 10:51 AM, the ADM stated care plans are updated and used by the direct care staff to know how to provide care for the residents. The ADM stated care plans were updated after IDT meetings by the IDT staff. He stated Resident #1's care plan did not reflect the interventions that were place for Resident #1. The ADM stated the care plan problem should reflect the resident-to-resident altercation and the interventions that were placed. He stated not having a care plan that reflected the problem with interventions for that problem could affect the resident by not giving the staff the needed direction to provide the needed services for the resident.Review of facility policy titled Comprehensive Care Plans, dated 10/24/2022, reflected Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive care assessment.Policy Explanation and Compliance Guidelines:1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed.3. The comprehensive care plan will describe, at a minimum, the following:a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.